

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35267**
4517

FILED NOV 15 1952		BIRTH NO. 69461		REG. DIST. NO. 149	PRIMARY REG. DIST. NO. 1002	Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If in institution: residence before admission) a. STATE Missouri b. COUNTY Jackson				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City			c. LENGTH OF STAY (In this place) 16 1/2 hrs				
d. FULL NAME OF HOSPITAL OR INSTITUTION Lakeview			d. STREET ADDRESS (If rural, give location) 1833 Cypress St.				
3. NAME OF DECEASED (Type or Print) a. (First) Marvlin b. (Middle) Sue c. (Last) Wax			4. DATE OF DEATH (Month) (Day) (Year) October 14-1952				
5. SEX Female		6. COLOR OR RACE white		7. MARRIED (NEVER MARRIED, WIDOWED, DIVORCED, SEPARATED) NEVER MARRIED		8. DATE OF BIRTH October 12-1932	
9. AGE (In years last birthday) 16 1/2		10. IF UNDER 1 YEAR Months 16 1/2		10. IF UNDER 24 HRS. Mins. 16 1/2		11. BIRTHPLACE (City and State or Foreign Country) Kansas City, Missouri	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY _____		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Pete Wesley Wax, Jr.	
13b. MOTHER'S MAIDEN NAME Fern Louise Ashburn		14. NAME OF HUSBAND OR WIFE _____		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT'S SIGNATURE OR NAME Father - Pete Wax - 1833 Cypress St.		18. ADDRESS 1833 Cypress St.		19. MEDICAL CERTIFICATION		20. INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: Massive bilateral atelectasis		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21c. (CITY, TOWN, OR TOWNSHIP) _____		21d. (COUNTY) _____		21e. (STATE) _____		21f. HOW DID INJURY OCCUR? _____	
21g. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21h. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21i. HOW DID INJURY OCCUR? _____		21j. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from Oct 13 to Oct 14 , 1952, that I last saw the deceased alive on Oct 14 , 1952, and that death occurred at 1:40 p.m. , from the causes and on the date stated above.		23a. SIGNATURE OF R. C. SHECK (Degree or title) R. C. Sheck, M.D.		23b. ADDRESS 11408 1/2 Winnetka Rd		23c. DATE SIGNED 10/14/52	
24a. BURIAL CREMATION (REMOVAL) (Specify) Buried		24b. DATE Oct 16, 52		24c. NAME OF CEMETERY OR CREMATORY Mound Grove		24d. LOCATION (City, town, or county) (State) Julesburg, Missouri	
DATE REC'D BY LOCAL REG. 10-16-52		REGISTRAR'S SIGNATURE Geraldine Smith		25. FUNERAL DIRECTOR'S SIGNATURE Poland R. Sheak		ADDRESS Julesburg, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

8100

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Wayne H. Halleman

Licensed Embalmer No.

4627

P. O. Address

Indep. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.